

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297047		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2009	
NAME OF PROVIDER OR SUPPLIER BOULDER CITY HOSP HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 901 ADAMS BLVD BOULDER CITY, NV 89005			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 000	<p>INITIAL COMMENTS</p> <p>This Statement of deficiencies was generated as a result of the Medicare Recertification Survey conducted at your agency on February 24, 2009.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>The active census at the time of the survey was 19. Ten clinical records were reviewed. Five home visits were conducted.</p> <p>The agency met all Conditions of Participation.</p> <p>The following regulatory deficiencies were identified:</p>			G 000			
G 121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</p> <p>The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>This STANDARD is not met as evidenced by: Based on review of clinical records, policy review and interview with agency staff, the agency failed to ensure care was provided in accordance with accepted standards of practice in 3 of 15 records reviewed. (#5, #10 and #12)</p> <p>Findings include:</p> <p>Patient #5 was admitted to the agency on 2/07/09</p>			G 121			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 121	<p>Continued From page 1</p> <p>with diagnoses of care following orthopedic surgery, lumbago, muscle weakness, decubitus ulcer of the heel and a pressure ulcer. Skilled nursing was ordered for 1 w 1 (one time a week for one week), 2 w 1 (two times a week for one week), 1 w 7 (one time a week for seven weeks) and two visits as needed for wound care complications. Physical therapy was ordered to evaluate and treat.</p> <p>The patient had a heel ulcer that required care. The wound measurement was documented at the start of care at 4 x 3 centimeters. The record lacked documented evidence of other measurements being done of the heel ulcer.</p> <p>Patient #10 was admitted to the agency on 12/28/08 with diagnoses of aftercare for a healing traumatic fracture, muscle weakness, essential hypertension and bone and cartilage disease. Skilled nursing was ordered for 2 w 5 (two times a week for five weeks), 1 w 4 (one time a week for four weeks) and two visits as needed for wound care.</p> <p>Wound care was mentioned on the treatment area of the plan of care for the skin tear on the arm and a wound on the right toe. Neither of these wounds were listed under the diagnoses for the plan of care.</p> <p>The clinical record review included the time period of 12/28/08 through 2/22/09. During this time period only one measurement of a wound was noted in the documentation. The wound was measured on 2/21/09.</p> <p>Patient #12 was admitted to the agency on 1/15/09 with diagnoses of retention of urine,</p>	G 121			

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G 121	Continued From page 2 muscle weakness, cancer of the scalp, renal failure and essential hypertension. Skilled nursing was ordered for 1 w 1 (one time a week for one week), 2 w 3 (two times a week for three weeks), 1 w 5 (one time a week for five weeks) and two visits as needed for catheter complications and wound care complications. Home health aide visits were ordered for 1 w 1 (one time a week for one week), 3 w 1 (three times a week for one week) and 1 w 7 (one time a week for seven weeks). The certification period for the care being provided by the agency was dated 1/15/09 through 3/15/09. Skilled nursing was providing wound care, at one time, to both the scalp and the buttock. During the time period of 1/15/09 through 2/15/09, there were only three wound measurements in the record. All three measurements were of the scalp wound. There were no measurements for the buttock wound. Interview with the Home Health Manager on the afternoon of 2/23/09 revealed that the agency policy was for wound measurements to be done weekly and documented in the clinical record.	G 121			
G 157	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, the agency failed to ensure the patient's	G 157			

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G 157	<p>Continued From page 3</p> <p>medical, nursing and/or social needs were met with reasonable expectation in a timely manner in the patient's place of residence in 2 of 15 patient's reviewed. (#15 and #5)</p> <p>Findings include:</p> <p>Patient #15 was admitted to the agency on 1/31/09 with diagnoses of acute bronchitis, essential hypertension, cellulitis, malaise and fatigue, chronic pain and diabetes. Skilled nursing visits were ordered for 1 w 1 (one time a week for one week), 3 w 1 (three times a week for one week), 2 w 7 (two times a week for seven weeks) and 2 visits as needed for wound care complications. Physical therapy and occupational therapy were to evaluate and treat.</p> <p>The clinical record lacked documented evidence of an occupational therapy evaluation at the time of record review on 2/23/09, 23 days after the start of care.</p> <p>Patient #5 was admitted to the agency on 2/07/09 with diagnoses of care following orthopedic surgery, lumbago, muscle weakness, decubitus ulcer of the heel and a pressure ulcer. Skilled nursing was ordered for 1 w 1 (one time a week for one week), 2 w 1 (two times a week for one week), 1 w 7 (one time a week for seven weeks) and two visits as needed for wound care complications. Physical therapy was ordered to evaluate and treat.</p> <p>Physical therapy was ordered for evaluation at the start of care. The evaluation was not completed until 2/10/09, the fourth day from the start of care. The record lacked documented evidence as to why the evaluation was delayed.</p>	G 157			

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G 157	Continued From page 4	G 157			
G 158	<p>At 3:45 PM on 2/23/09, during an interview with the Home Health Manager, she stated that the secondary disciplines were to see the patients within 72 hours of referral.</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>This STANDARD is not met as evidenced by: Based on interview with agency staff and review of clinical records, the agency failed to ensure agency staff administered care in accordance with the plan of care established by the physician for 5 of 15 patients. (#7, #12, #5, #15 and #9)</p> <p>Findings include:</p> <p>Patient #7 was admitted to the agency on 12/17/08 with diagnoses of care of a port-a-cath, diabetes and multiple myeloma with remission. Skilled nursing visits were ordered for 1 w 3 (one time a week for three weeks) and two visits as needed.</p> <p>The patient was seen at the start of care on 12/17/08 and then not again until 1/06/09, nearly three weeks later. The clinical record lacked documented evidence that the physician had been notified of all of the missed visits and the record lacked documented evidence of an order to change the frequency as ordered originally on the plan of care.</p>	G 158			

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G 158	<p>Continued From page 5</p> <p>Patient #12 was admitted to the agency on 1/15/09 with diagnoses of retention of urine, muscle weakness, cancer of the scalp, renal failure and essential hypertension. Skilled nursing was ordered for 1 w 1 (one time a week for one week), 2 w 3 (two times a week for three weeks), 1 w 5 (one time a week for five weeks) and two visits as needed for catheter complications and wound care complications. Home health aide visits were ordered for 1 w 1 (one time a week for one week), 3 w 1 (three times a week for one week) and 1 w 7 (one time a week for seven weeks).</p> <p>The record lacked documented evidence that the patient was seen by skilled nursing during the week of 2/1/09.</p> <p>The home health aide visits provided to the patient were as follows: One time a week for one week, two times a week for four weeks and one time a week for the week of 2/15/09. The clinical record lacked documented evidence that the physician had been notified of the need to change the plan of care for the home health aide.</p> <p>Patient #5 was admitted to the agency on 2/07/09 with diagnoses of care following orthopedic surgery, lumbago, muscle weakness, decubitus ulcer of the heel and a pressure ulcer. Skilled nursing was ordered for 1 w 1 (one time a week for one week), 2 w 1 (two times a week for one week), 1 w 7 (one time a week for seven weeks) and two visits as needed for wound care complications. Physical therapy was ordered to evaluate and treat.</p> <p>The clinical record lacked documented evidence that the patient was seen twice by skilled nursing</p>	G 158			

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G 158	<p>Continued From page 6</p> <p>the second week of the plan of care. There was only one visit made by skilled nursing for that week. The clinical record lacked documented evidence that the physician had been notified of the need to change the plan of care.</p> <p>Patient #15 was admitted to the agency on 1/31/09 with diagnoses of acute bronchitis, essential hypertension, cellulitis, malaise and fatigue, chronic pain and diabetes. Skilled nursing visits were ordered for 1 w 1 (one time a week for one week), 3 w 1 (three times a week for one week), 2 w 7 (two times a week for seven weeks) and 2 visits as needed for wound care complications. Physical therapy and occupational therapy were to evaluate and treat.</p> <p>The clinical record lacked documented evidence of visits being made by skilled nursing according to the frequency ordered on the plan of care. There was only a missed visit report in the record dated 2/07/09 along with the start of care documentation on 1/31/09. The clinical record lacked documented evidence of visits being made by physical therapy according to the frequency ordered on the evaluation. There were no other visits documented after the evaluation was completed on 2/01/09.</p> <p>During an interview with the Home Health Manager on the morning of 2/24/09, she stated that the staff were not required to write verbal orders for a change to the plan of care related to a decrease in visits.</p> <p>Patient #9 was admitted on 2/11/09, with diagnoses including spinal stenosis of the lumbar spine and osteoarthritis.</p> <p>The home health certification and plan of care</p>	G 158			

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G 158	Continued From page 7 indicated the certified nursing assistant (CNA) was to see Patient #9 once a week for one week and then, two times a week for eight weeks. The clinical record lacked documentation of a CNA visit the week of 2/8/09. The clinical record lacked documented evidence that the physician had been notified of the need to change the plan of care.	G 158			
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on interview with agency staff and review of clinical records, the agency failed to ensure the plan of care from patient to patient and certification period to certification period covered changes in all pertinent diagnoses and goals for 9 of 15 records reviewed. (#15, #10, #5, #8, #12, #1, #7, #9 and #11) Findings include: During the course of clinical record review, it was noted that there was no difference in the goals for each patient as listed on the plan of care. The goal of: "Patient/caregiver will verbalize the understanding of nature and complications of	G 159			

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G 159	Continued From page 8 disease process this certification period" was listed under skilled nursing goals for the following patients. Patient #15, #10, #5, #8, #12, #1, #7(for both certification periods with no change), #9 and #11. The goal of: "Patient/caregiver will verbalize and demonstrate the importance of diet, activities, medications and treatment this certification period" was listed under skilled nursing goals for the following patients. Patient #15, #10, #5, #8, #1, #7(for both certification periods with no change), #9 and #11. The goal of: "Patient/caregiver will demonstrate effective pain control at the patient's own comfort level as verbalized by patient/caregiver this certification period" was listed under skilled nursing goals for the following patients. Patient #10, #5, #8, #1, #9 and #11. Patient #10 was admitted to the agency on 12/28/08 with diagnoses of aftercare for a healing traumatic fracture, muscle weakness, essential hypertension and bone and cartilage disease. Skilled nursing was ordered for 2 w 5 (two times a week for five weeks), 1 w 4 (one time a week for four weeks) and two visits as needed for wound care. Wound care was mentioned on the treatment area of the plan of care for the skin tear on the arm and a wound on the right toe. Neither of these wounds were listed under the diagnoses for the plan of care.	G 159			
G 161	484.18(a) PLAN OF CARE Orders for therapy services include the specific procedures and modalities to be used and the	G 161			

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G 161	Continued From page 9 amount, frequency, and duration. This STANDARD is not met as evidenced by: Based on clinical record review, the facility failed to ensure orders for therapy services included a specific duration for 1 of 15 patients. (#2) Findings include: Patient #2 was an 84 year-old, admitted on 2/12/09, with diagnoses including hemiplegia, hypertension and urge incontinence. The plan of care and physician's order for occupational therapy (OT), dated 2/17/09, read, "Two times a week for two to three weeks." The duration was not finite.	G 161			
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on clinical record review, the agency failed to administer drugs and treatments only as ordered by the physician for 3 of 15 sampled patients (#3, #11 and #10). Findings include: Patient #3 was admitted on 2/13/09, with chronic back pain secondary to osteoarthritis. The physical therapy (PT) care plan, dated 2/18/09 read, "Two times a week for six weeks." The clinical record contained PT notes dated	G 165			

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G 165	<p>Continued From page 10</p> <p>2/18/09, 2/19/09 and 2/21/09, revealing three visits were made during the week of 2/16/09. The clinical record lacked documented evidence that an order for the extra PT visit had been obtained from the physician.</p> <p>Patient #11 was admitted on 1/20/09, with diagnoses including pressure ulcer, chronic airway obstruction and weight loss.</p> <p>A daily clinical revisit note, dated 1/27/09, indicated Patient #11 had developed a new pressure ulcer. There was no indication on the daily clinical revisit note the physician had been notified of the new pressure ulcer. The clinical record lacked documented evidence that an order for wound care to the new pressure ulcer had been obtained.</p> <p>Patient #10 was admitted to the agency on 12/28/08 with diagnoses of aftercare for a healing traumatic fracture, muscle weakness, essential hypertension and bone and cartilage disease. Skilled nursing was ordered for 2 w 5 (two times a week for five weeks), 1 w 4 (one time a week for four weeks) and two visits as needed for wound care.</p> <p>Skilled nursing provided visits per the plan of care for the first two weeks of the certification period. On the third week of the certification period, skilled nursing visits were increased to daily on 1/13/09. The clinical record lacked documented evidence that the physician had been contacted regarding the change to the plan of care to increase the skilled nursing visits to daily. The only documentation in the clinical record addressing the increase in skilled nursing visits was dated 2/16/09 and revealed the following: "Increase SN visits to daily, except for days</p>	G 165			

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G 165	Continued From page 11 patient goes to wound clinic (next visit scheduled for 2/23/09)." There was no duration to the frequency as it was written and no documented evidence that the physician had been consulted for clarification.	G 165			
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on clinical record review and observation, the agency failed to provide adequate written patient care instructions for the home health aide to care for the patient for 1 of 15 patients. (#12) Findings include: Patient #12 was admitted to the agency on 1/15/09 with diagnoses of retention of urine, muscle weakness, cancer of the scalp, renal failure and essential hypertension. Skilled nursing was ordered for 1 w 1 (one time a week for one week), 2 w 3 (two times a week for three weeks), 1 w 5 (one time a week for five weeks) and two visits as needed for catheter complications and wound care complications. Home health aide visits were ordered for 1 w 1 (one time a week for one week), 3 w 1 (three times a week for one week) and 1 w 7 (one time a week for seven weeks). The patient was receiving care from a home health aide with a home health aide care plan	G 224			

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G 224	Continued From page 12 assigned by the registered nurse. The care plan was dated 1/15/09 and included catheter care. The home health aide note dated 2/17/09 revealed that the catheter had been removed at the physician's office and the patient did not have one any longer. Supervisory visits on the home health aide were completed as required for this patient by skilled nursing. The clinical record lacked documented evidence that the registered nurse updated the home health aide care plan to reflect the change in care for the patient. The care plan for the home health aide still contained instructions for catheter care at the observation of the home visit on 2/24/09.	G 224			
G 303	484.48 CLINICAL RECORDS The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, the agency failed to demonstrate that discharge summaries were available to the physician that contained pertinent information on the care of the patient in 1 of 15 patient records reviewed. (#4) Findings include: Patient #4 was admitted to the agency on 10/01/08 with diagnoses of malaise and fatigue, osteoporosis and diabetes. The patient was seen by skilled nursing, home health aide, occupational therapy, physical therapy and social worker	G 303			

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G 303	Continued From page 13	G 303			
G 337	<p>484.55(c) DRUG REGIMEN REVIEW</p> <p>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>This STANDARD is not met as evidenced by: Based on clinical record review and patient/caregiver interview, the agency failed to ensure a comprehensive review of medications was completed for 3 of 15 patients. (#2, #11 and #12)</p> <p>Findings include:</p> <p>Patient #2 was admitted on 2/12/09, with diagnoses including hemiplegia, hypertension and urge incontinence.</p> <p>On 2/24/09 during a home visit at 8:00 AM, Patient #2 revealed four additional medications and/or supplements which were not listed on the home health certification and plan of care initiated on 2/12/09. The clinical record lacked documentation of additional orders for the four</p>	G 337			

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G 337	<p>Continued From page 14 additional medications and/or supplements.</p> <p>Patient #2 indicated she took a Centrum multivitamin by mouth every day at noon, a Citracal Plus with Magnesium and Vitamin D at bedtime, placed Patonal one drop in each eye as needed for itching, and took four capsules of Clindamycin 150 milligrams one hour prior to dental appointments. The patient indicated she was taking these before home health services started.</p> <p>Patient #11 was admitted on 1/20/09, with diagnoses including pressure ulcer, chronic airway obstruction and weight loss.</p> <p>The home health certification and plan of care indicated Patient #11 was taking Xanax 0.5 milligrams one tablet by mouth three times a day. The prescription bottle label read, "Xanax 0.5 milligrams one tablet by mouth four times a day and two tablets at bedtime."</p> <p>On 2/24/09 at 1:30 PM, Patient #11 indicated he took Xanax 0.5 milligrams one tablet in the morning when he woke up, one at 10:00 AM, one at 2:00 PM and two tablets at bedtime. Patient #11 indicated his wife set up his meds and didn't want him taking the fourth dose of one tablet during the day. The clinical record lacked documented evidence the physician had been called for clarification of the order.</p> <p>The home health certification and plan of care indicated Patient #11 was taking Trazadone 100 milligrams one tablet by mouth at bedtime. The prescription bottle label read, "Trazadone 100 milligrams two tablets by mouth at bedtime." Patient #12 was admitted to the agency on</p>	G 337			

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G 337	<p>Continued From page 15</p> <p>1/15/09 with diagnoses of retention of urine, muscle weakness, cancer of the scalp, renal failure and essential hypertension. Skilled nursing was ordered for 1 w 1 (one time a week for one week), 2 w 3 (two times a week for three weeks), 1 w 5 (one time a week for five weeks) and two visits as needed for catheter complications and wound care complications. Home health aide visits were ordered for 1 w 1 (one time a week for one week), 3 w 1 (three times a week for one week) and 1 w 7 (one time a week for seven weeks).</p> <p>On 2/24/09 at 10 AM, a home visit was conducted. The patient's son (caregiver) was staying with the patient. The caregiver was interviewed about the patient's medications. The patient's medications as provided by the caregiver were as follows:</p> <p>Citracal one tablet twice a day Ocuvite one tablet twice a day Lisinopril 10/12.5 milligrams one table daily (ordered on 2/18/09) Atenolol 25 milligrams ½ tablet daily Klor-con M10 one tablet daily</p> <p>The plan of care dated 1/15/09 listed the following medications:</p> <p>Atenolol 25 milligrams daily Klor-con 10 millequivilants daily Flomax 0.4 milligrams daily at bedtime</p> <p>Only one of the medications listed on the plan of care was what the patient was actually taking. The clinical record lacked documented evidence that the medications taken by the patient had been updated in the clinical record or in the</p>	G 337			

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G 337	Continued From page 16 record left in the home. The clinical record lacked documented evidence that the physician had been consulted for clarification of the medications.	G 337			